Results: Hospital mortality was 11% (16 patients died). Predictive clinical factors of in-hospital mortality were: age over 60 years (OR=23.7, P<0.001), history of COPD (OR=5.04, P=0.006) or stroke (OR=23.7, P<0.001), respiratory rate> 25 cycles per minute (OR=18.6, P=0.007) and presence of motor deficit (OR=7.92, P<0.001) or signs of right heart failure (OR=3.45, P=0.032) or left ventricular failure (OR=10.41, P <0.001). Predictive echocardiographic factors of in-hospital mortality were: right ventricular dilatation (OR=1.27, P=0.011), dilatation of the right atrium (OR=1.37, P=0.003), presence of pulmonary hypertension (OR=1, 21, P=0.029) and the presence of a paradoxical septum (OR=37, P<0.001). A hospital stay of more than 8 days was significantly associated with mortality (OR=4.14, P=0.006).

Conclusion: A better understanding of predictors of hospital mortality in pulmonary embolism is used to define a population at high risk witch warrants more aggressive therapy. These data must be confirmed by prospective studies.

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Contribution and comparison of the wells score with the Geneva score and revised Geneva score for assessing pretest probability of pulmonary embolism in emergency department: Tunisian experience

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Introduction: In recent years, clinical assessment of pretest probability has become a crucial tool in the diagnostic approach of patients with suspected pulmonary embolism (PE). Study objective

Study and compare the predictive accuracy of clinical prediction scores: the Wells score(WS) with the Geneva score(GS) and revised Geneva score(RGS) in the assessment of pretest probability of PE

Methods: It is a monocentric, retrospective study concerning 150 patients having diagnosed with deep venous thrombosis(DVT) hospitalized in the emergency department during the period from January 1997 to December 2008.

Results: The study population consisted of 150 patients diagnosed with DVT confirmed by lower limb ultrasonographic examination. A total of 34 (23 %)) patients were diagnosed with PE. The distribution of the patients according to the groups and the under groups in the three clinical prediction scores as well as the frequency of PE are summarized in this table below

The comparison of the predictive accuracy of the SW and the SG showed an area under the ROC curve of 0,889 for the SW and 0,834 for the SG with a slight superiority of the score of wells. the concordance between these two scores was moderated (u =0,58). The SGR had an inferior concordance compared to the SW (u =0,4) and SG (u =0,278)

Table – The distribution of the patients according to the groups and the under groups in the three clinical prediction scores

Clinical propability	Wells score (N=150) N(%)	Geneva score (N=150) N(%)	revised Geneva score (N=150) N(%)
low	0	122(81.3)	2(1.4)
moderete	129(86)	26(17.3)	93(62)
high	21(14)	2(1.4)	55(36.6)
p	<0.001	<0.001	0.028
Frequency of the PE	N(%)	N(%)	N(%)
low	0	19(16)	2(100)
moderete	19(15)	14(54)	19(19.4)
high	15(71)	1(50)	13(23.6)

Conclusions: In our population the Wells score appeared to be more accurate than the Geneva score and the simplified revised Geneva score. The impact of this finding in terms of patient outcomes should be investigated in a prospective study.

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Intravenous aldosterone blockade at presentation improves myocardial perfusion after primary PCI for STEMI

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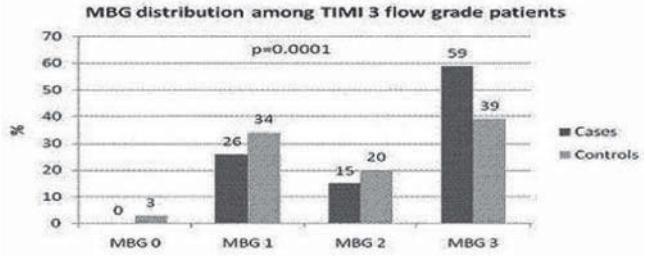
Purpose: High aldosterone levels are associated with vascular injury and poor outcome after STEMI. We hypothesized that early aldosterone receptor blockade at admission for primary PCI may improve myocardial perfusion.

Methods: 159 consecutive patients admitted for primary PCI for STEMI were treated by 200 mg IV potassium canrenoate at presentation. The patients were randomly matched to 318 patients based on the admission GRACE score's deciles. Myocardial blush grade (MBG) was assessed in all patients by 2 operators blinded to the treatment. The outcome of the study was the rate of MBG 3 after primary PCI. A multivariable conditional logistic regression model adjusted on abciximab and thienopyridine pre-treatment, and the symptom to needle time was used to compare cases and controls.

Results: cases and controls were comparable regarding age (63±14 vs 62±14) gender (mal 81 vs 79%), and baseline risk factors. Cases presented later (7.7±9.5 vs 5.6±5.4, p=NS) and were less often treated by abciximab (75 vs 84%, p<0.05).

TIMI flow grades prior and after primary PCI were comparable between cases and controls. Based on TIMI flow grade the success rate was comparable between cases and controls (87 vs 90%). MBG 3 rate was significantly higher in cases than in controls with an adjusted OR 2.23 (95%CI 1.40-3.55). Figure depicts the distribution of post-PCI MBG among cases and controls.

Conclusions: Early aldosterone blockade on admission for primary PCI is associated with improved myocardial reperfusion as assessed by MBG. These findings underscore the vasculoprotective effects of aldosterone blockade early after STEMI.



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Clinical outcomes in advanced acute heart failure (AHF) patients stratified by INTERMACS classification

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Purpose: Risk stratification in patients presenting severe heart failure in the Intensive Care Unit (ICU) with acute decompensation is difficult. The Interagency Registry for Mechanically Assisted Circulatory Support (INTERMACS) had defined seven clinical Profiles to describe patients